DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 10172 (05/06)

AGENCY RESPONSE TO THE STATE QUALITY ASSURANCE (QA) MEDICAID FINDING

Complete, sign and return this form with documentation to:

Wisconsin Department of Health & Family Services
Division of Health Care Financing
Attn: Vicki Jessup
Bureau of Eligibility Management
P.O. Box 309
Madison, WI 53701-0309

CARES Case Number	**Case Name**

☐ **We agree with the error finding.**
If necessary**,** correct the case and submit documentation of your corrective action within 30 days. If an overpayment occurred due to client error, establish a claim to initiate benefit recovery. To assist with error reduction initiatives, indicate what information from the client, agency or state would have helped prevent this error? **Please respond within 30 days.**

☐ **We disagree with the error finding.**
Provide additional information and/or documentation to explain why you consider the eligibility determination to be correct. **Please respond within 14 days.**

☐ **If client error, was this case referred for fraud?**

SIGNATURE – Agency Representative	Date Signed
SIGNATURE – Agency Supervisor	Date Signed

AGENCY NAME

Reset Form